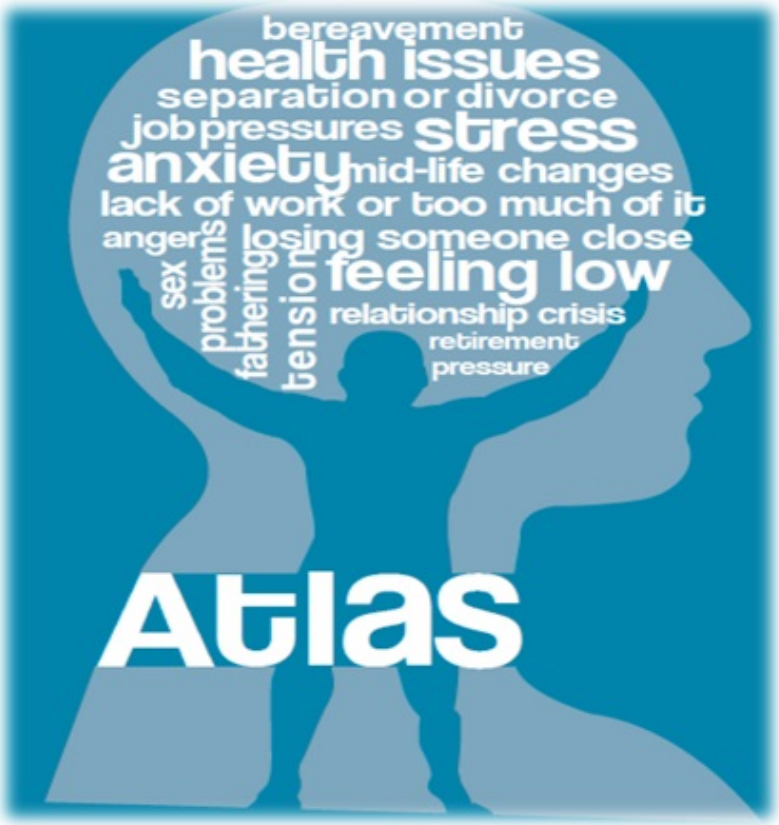
Atlas Men's Well-being Programme: Evaluation Report Atlas 2.0

Prepared by:
Dr Ilham Sebah (Research Fellow)
Dr Anna Cheshire (Research Fellow)
Professor Damien Ridge (College Research & Institute Director)
December 2020



For more information about Atlas or the evaluation contact:

Professor Damien Ridge
College Research & Institute Director
College of Liberal Arts & Sciences
University of Westminster
115 New Cavendish Street
London W1W 6UW
d.ridge@westminster.ac.uk

Contents

Executive Summary

Background to the evaluation

Men's suicide rates remain an issue of concern in the United Kingdom (UK). In England and Wales, males accounted for around three-quarters of suicide deaths registered in 2019 (4,303 male deaths compared with 1,388 female deaths). Men do not always utilise health services and may be reluctant to access help from professional mental health services, thus indicating a need to better understand men's distress, as well as services that enable men to cope better. The Atlas men's well-being programme was created with the intention of addressing distress, and to improve access to mental health services for men. Atlas, originated by Professor Damien Ridge and co-designed with Professor David Peters, was designed to be 'male sensitive' and provide counselling and/or acupuncture to men suffering from stress or distress. Atlas is based at the Victoria Medical Centre (VMC), a busy NHS GP practice in Central London with over 18,000 patients on their books. Atlas was first piloted from March 2014 until July 2014 for practice patients. An evaluation study of the original Atlas Men's wellbeing pilot programme showed improvements in patient's mental and physical health (Cheshire, Peters, & Ridge, 2016), with high acceptability for both men who attended as well as VMC staff. Atlas 2.0, a continuation of the pilot service based at the VMC, ran from September 2017 to the present day. The current report is an evaluation of data for this service up until March 2020.

Methods

Questionnaires: All patients using Atlas 2.0 were invited to take part in the evaluation. Questionnaires were used to collect predominantly quantitative data and were completed by patients prior to using the Programme as well as on finishing the Programme. Measures collected included anxiety, depression, perceived stress, positive well-being and physical health. Open-ended questions collected written data regarding patient experience of the Atlas Programme.

Key Findings

- GPs continued to play a key role in referring and encouraging men to attend Atlas.
- Of the 25 patients using the Programme, 16 (64%) completed both a pre-treatment questionnaire and post-treatment questionnaire.
- At baseline patients were reporting moderate levels of anxiety and low levels of depression.
- The findings indicate that patients referred to the services self-reported a wide range of levels of anxiety and depression, however anxiety was much more prevalent in this population than depression. This reflects the remit of the programme, which was tailored for patients suffering from everyday 'stress or distress' rather than diagnosable depression.
- A large proportion of patients had been using medication (prescribed or over the counter) and/or alcohol as a way to manage their distress.
- Comparisons between pre- and post-treatment revealed statistically significant improvements in anxiety and perceived stressed.

- Overall there was no statistically significant change in depression, but this is likely to be because a significant proportion of the men using the Programme were not initially identified as depressed. However, 44% of men experienced a clinically significant improvement in depression after Atlas, these changes were typically experienced when men had did have high depression scores on entering Atlas, suggesting Atlas can help with depression.
- There were no statistically significant changes found for depression, positive well-being or physical health.
- Qualitative data supported findings of improved stress levels and anxiety reduction, and suggested men had an improved awareness and understanding of themselves and their problems, attending Atlas contributed to these improvements.
- Patients also reported a number of helpful techniques that they had learned from Atlas sessions that they felt contributed to their well-being and ability to manage their stress, for example, breathing exercises and visualisation.

Quotes from Atlas participants:

"*I was in a very bad place, with suicidal thoughts. I am now feeling emotions, taking more active control of my life. My chronic headaches have virtually disappeared and my anxiety is under better control."*

"I am more at peace with myself."

"*I have more courage. I can now deal with my situation. I feel stronger & more powerful."*

"Learned techniques to deal with anxiety, to question my emotions rather than bottle them up."

Conclusions

The evaluation demonstrates a hitherto under-investigated pathway by which men experiencing mental health problems can be identified in primary care and helped to talk about the problems that are concerning them, and/or receive physical therapy aimed at reducing stressed-related symptoms (or a combination of both).

Findings from this evaluation suggest that the Atlas Men's Well-being Programme was helpful for stressed and distressed men, particularly in terms of reducing anxiety and stress. Men were supported to understand their emotions and how to better deal with their them, resulting in feeling of increased confidence and well-being.

This service and evaluation contribute to our knowledge and understanding of how to best support men and tackle the often neglected topic of their mental health in everyday primary care.

Acknowledgements

We would like to thank:

- MyWestminster Fund, Quintin Hogg Trust, University of Westminster and Nelsons for funding the ongoing Atlas project and evaluation.
- Susan and Richard Kilsby for their seed-funding which helped support the evaluation.
- Dr Susan Rankine (Senior Partner at the VMC) for facilitating the delivery of Atlas at the VMC and supporting the evaluation.
- All the Victoria Medical Centre (VMC) staff who assisted with the delivery, promotion and referrals to the Programme, including GPs, administration/reception staff and other VMC staff. In particular, Bernadette Boyse for her help with collecting questionnaires and general administration of Atlas
- The Atlas practitioners, including Professor David Peters (Atlas Programme Director), Ros Guthrie (counsellor) and Anna Kiff (acupuncturist), for facilitating the delivery of the evaluation and their professional delivery of the Programme.
- All patients who participated in the Programme and completed the evaluation assessments and all stakeholders who took time to participate in evaluation interviews.

Background Literature

Men's mental health and wellbeing

Historically, the health of men has been under researched (White et al., 2011; World Health Organisation, 2000; Baker, 2016; Milligan, Dowrick, & Payne, 2013). Whilst men's life expectancy continues to improve in many countries (European Commission, 2011) and is improving at a higher rate than women's in the UK (Bennett et al., 2015), significant issues remain in relation to understanding the wider factors that affect men's health practices and their engagement in health promotion (Robertson et al., 2016). Globally, a number of key health outcomes are poorer for men than for women (Baker, 2018). Within the United Kingdom (UK), men's lower life expectancy and high rates of premature mortality, particularly in low-income groups, continues to be of considerable concern (Marmot, 2010). In England and Wales from 2008-2010, men aged between 25-65 years in the highest socioeconomic group had a mortality rate 3.4 times lower compared with men in the lowest socioeconomic group (ONS, 2013). One persistent reason for these differences in premature death rates that is attributed to sex differences is suicide; suicide rates have consistently been reported to be higher in men compared to women since records began (Haggett 2015; WHO, 2017). Men accounted for three-quarters of UK deaths by suicide in 2019 (ONS, 2019). Suicide remains the most common cause of death in men under the age of 35, and it is at record levels among middle-aged men (aged 45-49) (Samaritans, 2018). Suicide amongst males is linked to issues such as alcoholism, isolation, economic hardship and not reaching out for help (ONS, 2019).

A consistent finding in the help-seeking literature is that men are less likely to seek help for physical and mental health problems than females (Addis & Mahalik, 2003), a finding that includes men of different ages, nationalities and ethnic backgrounds (Addis & Mahalik, 2003). Men do not always utilise traditional health services (Conrad & white, 2010, and may be especially reticent to access help from mental health services, even in severe cases, where instead some take their own lives (Sullivan et al. 2015). In cases where men do engage in treatment, they are frequently socially isolated (Kawachi & Berkman, 2001) and more likely to drop-out (Cottone et al., 2002). Fewer men than women are treated for 'common mental disorders' (Deverill & King, 2009), both in the UK (Richards & Borglin) and elsewhere (Addis, 2008). However, these differences are unlikely to be due to prevalence rates, but rather complex issues, such as men presenting in atypical ways or seeking general medical care less often than women, especially for preventative health reasons (Courtenay, 2000). Men are more likely to report wanting to deal with mental health problems on their own (Welford & Powell, 2014), or may reach higher thresholds of distress before they seek help compared to women (Ridge, Emslie, & White, 2001). It has also been argued that men's help-seeking behaviours are influenced by social constructions of masculinites (Courtenay, 2009), not only impacting on their help seeking behaviours, but also collusion by professionals by way of keeping male distress hidden (Doyal et al., 2003; Courtenay, 2009)

Traditional gender-role socialisation theories postulate that social environments teach men and women divergent sex-type behaviours and attitudes that influence how they view themselves, in terms of gendered expectations for their behaviour (Mansfield et al., 2003). For example, masculine scripts encourage independence, strength, invulnerability and

winning, thus making it challenging for a man aligned to such norms to seek professional help for mental health problems (Sullivan et al., 2015). What is expected in terms of appropriate gender behaviour for men, especially with reagrds to being rational, stoical and not dispalying weakness, is also thought to play a role in men's reluctance to engage with mental health and wellbeing interventions (Kingerlee et al., 2014). When men experience problems, masculine norms can encourage social withdrawal, alcohol and substance abuse, increased work hours, and anger fuelled conflict to cope (Brown, Sagar-Ouriaghli & Sullivan, 2019), with suicide frequently positioned as a brave or otherwise masculine attempt to re-gain control (Emslie et al. 2006; Olife et al. 2012). Men who subscribe strongly to traditional masculine norms also tend to have poorer mental health and less favourable attitudes towards seeking psychological help. However, not all masculine norms are equally implicated, e.g. those who attach more importance to self-reliance appear to be more at risk (Wong, Ho & Wang, 2017).

There is growing recognition that the relationship between masculinity-related constructs and mental health-related outcomes, is more nuanced than previously believed and may be contingent on the manner by which 'masculinity' is operationalised (Wong et al., 2016), the types of outcomes and specific dimensions of masculinities involved (Levant, Wimer & Williams, 2011), and the kinds of populations that are studied (Levant, Wong, Karakis, & Welsh, 2015). Furthermore, elements of masculine norms, particularly those centred on control and responsibility, have been shown to be an effective resource for men coping with mental distress (Emslie et al., 2006; Valkonen & Hanninen, 2012). For example, some men are not reluctant to seek help and there are instances in which men willingly use health services (Ridge, Emslie, & White, 2011). One study found that fire-fighters constructed their gender identity around having a fit body in order to work effectively; they therefore perceived help-seeking as a means of preserving their careers and masculinity (O'Brien et al., 2005). There is evdience that, once enageged in behaviour change programmes, men can be more likely than women to have positive outcomes (Robertson, Archibald & Avenell, 2014), perhaps due to their tendency to focus on achievement. Men who do not normally utilise health services (or who do so reluctantly because they feel constrained by male norms), often change their behaviour in positive ways when the services are designed and delivered in a way that is gender sensitive (Baker, 2018).

Services for men

The importance of gender-sensitivity in the design and delivery of health services for men has been highlighted in several UK studies (Hunt, Wyke, & Gray, 2014; Robertson, Archibald, & Avenell, 2014; Galdas, P., Darwin, Z. & Kidd, 2014). There is some evidence that men may want different things from women from their health professionals. For example, studies have shown that while both men and women with depression could find it challenging to communicate their problems to health professionals, women stressed the importance of being listened to, whereas men valued health professionals who enabled them to talk about their distress (Emslie et al., 2007). It has also been suggested that men have a preference for short-term, directive goal-oriented, action-focused interventions based on problem-solving strategies, emphasising the practical utility of CBT over other forms of 'just talking' therapies (Emslie et al. 2007; Kingerlee et al. 2014).

Public health campaigns in the UK, including the Campaign Against Living Miserably (CALM), Samaritans, Rethink, Men's Health Forum and Men's Minds Matter have focused on raising awareness of the issues faced by men, seeking to legitimise and redefine help-seeking as a strength, and have encouraged men to open up and support one another (Brown, Sagar-Ouriaghli & Sullivan, 2019). For example, reframing help-seeking as a preventative action (Brown, Sagar-Ouriaghli & Sullivan, 2019) or as a means of looking after others (Emslie et al. 2006), are suggested as ways of increasing male help-seeking. It is hypothesised that using direct, solution-focussed approaches may allow men to give up one form of masculine capital (De Visser et al., 2009), that of being stoical, whilst demonstrating a high degree of other forms of masculine capital—particularly rationality (Robertson et al., 2018). Drawing on these aspects of masculinity has also been shown to be useful for men in re-establishing a valued male identity when dealing with depression (Emslie et al., 2006; Oliffe et al., 2012). Thus, recognising men's help-seeking practices as somewhat contradictory, fluid and contextual allows for those involved with interventions to identify the best approaches to maximise men's opportunities and likelihood of engaging in positive care practices (Robertson et al., 2018).

It is clear that within mental health areas, the conflict between traditional (hegemonic) notions of masculinity (e.g. the importance of emotional control and rationality) and engagement with initiatives is significant, more so than in relation to physical health concerns (Robertson et al., 2018). Careful attention to language and male-positive approaches are needed to ensure that men feel valued and engaged rather than alienated, marginalised or stigmatised: that is, approaches need to be sensitive to men's requirement to safeguard their identity as men rather than feeling that engagement necessarily requires surrendering masculinity (Robertson et al., 2018). However, it is equally important to be mindful of the risks related to reinforcing aspects of masculinity that have been implicated in health-defeating practices by utilising 'male friendly' approaches (Gough, 2009; Fleming et al., 2014). Thus, mental health promotion interventions face a challenge in engaging men in ways that apply aspects of masculinity in order to develop trust, while simultaneously not reinforcing values associated with negative health practices.

Counselling and acupuncture for distressed men

When working with men, the Samaritans' report on suicide recommends that psychological factors ought to be addressed alongside the prescription of psychotropic medication (Wyllie et al., 2012). Research has shown that patients with symptoms of anxiety and depression prefer psychological treatment over medication, and are keen to access non-pharmacological help such as self-help, psychological treatments and complementary therapies (Prins et al., 2008; Jorm, 2000; Kessler et al., 2001). They value not only improvements in their symptoms, but also broader changes - such as improvements in understanding, coping, daily functioning and quality of life - to which these treatments often lead (Zimmerman et al., 2008). Further, it has been suggested that non-pharmacological treatment options for depression are of interest to many patients, in part because of concerns regarding the adverse effects, fears of dependency on antidepressants and stigma (Cartwright et al., 2016). Among non-pharmacological treatments, acupuncture and counselling have shown some potential in the treatment of depression (MacPherson et al., 2017).

Counselling

NICE guidance suggests that, in the first instance, psychological/psychosocial interventions and self-help should be offered to patients with mild to moderate depression and generalised anxiety disorders (NICE, 2009; NICE, 2011). The Increasing Access to Psychological Therapies (IAPT) service was created in 2011 as a first-line treatment for depression and anxiety disorders. This programme is based on cognitive behavioural therapy (CBT) and is accessed through primary care. However, research has indicated that IAPT may appeal to women more than men, and only half of people referred to IAPTs entered treatment (HSCIS, 2014), where waiting lists can be long: in 2019 12.7% (more than 6,000 patients) waited longer than six weeks for treatment and a further 1.2% patients had to wait more than 18 weeks (NHS Digital, 2019). These figures highlight a serious need to expand the range of psychological services in the NHS. Additionally, the longer someone has to wait for treatment, the greater the risk they will become more seriously unwell and potentially require more intensive treatment as a result. Recent data from the IAPT programme also highlights that those from Black, Asian and Ethnic Minority communities are less likely to use IAPT services and complete treatment (Baker, 2018). It is clear that different types of therapy work for different people and a variety of options need to be available (MIND, 2014; Brettle, 2008). Thus, it is important to offer a range of psychological and psychosocial interventions to men (NCCMH, 2010).

Counselling is a popular talking therapy (The Guardian); it is less directive than CBT but has been shown to be as effective for anxiety, depression and non-specific psychological problems (Brettle et al., 2008). . A Cochrane review of counselling for mental health and psychosocial problems in primary care found that counselling was more effective in the short-term rather than the long-term (Bower, 2011). It also found that patient satisfaction with counselling is high and that the overall costs of counselling and usual care were similar (Bower, Rowland, & Hardy, 2003).Despite being an important option for psychological support, in more recent years counselling has been 'squeezed out' of primary care and the NHS and is less widely available to patients (Ryan, Duncan & Moller, 2019).

Acupuncture

Acupuncture has long been used as a treatment for stress-related disorders (Wild et al., 2020), with some studies demonstrating that acupuncture may be effective for individuals with increased stress (Huang et al., 2011), generalised anxiety (Pilkington, 2007), and some forms of post-traumatic stress disorder (Hollifield, et al., 2007). In a recent systematic review and meta-analysis on acupuncture treatment for depression, acupuncture showed clinically significant reductions in the severity of depression compared to usual care (Armour et al., 2019). It is common for men to seek out physical activity, such as exercise, when experiencing stress as opposed to talking about the causes of their stress (Wilkins & Kemple, 2010). Thus, it may be beneficial to offer a physical therapy option, like acupuncture, particularly for somatic presentations (Schroer, MacPherson, & Adamson, 2009). This offers a way to initially engage men in a treatment that is not centred on discussing difficult emotions, and therefore provides them with an alternative pathway into professional care.

The need for 'male-friendly' mental health services to be delivered through a range of methods is clear (Oliffe & Phillips, 2008), and the Atlas Men's Wellbeing Programme offers

an example of one such approach – offering counselling and/or accupuncture for stressed/distressed men (Cheshire et al., 2016).

The Atlas Men's Well-being Programme

The Atlas men's well-being programme was developed out of the current literature, our research and theorising on men, gender and distress, in conjunction with recruited Atlas practitioners and the Victoria Medical Centre, VMC (a GP practice where Atlas is based). The VMC provides a large number of services from purpose-built premises situated in Central London. Development work with the VMC ensured the service as attuned to the needs of their male patients. Prof Ridge originally developed a proposal to develop and study a 'male-friendly' counselling and acupuncture service for men in distress in 2012 (Ridge et al., 2011; Ridge, 2012), with input from Prof David Peters, an Expert Advisory Panel and Dr Anna Cheshire to further develop the project and evaluation. Expert input from VMC staff (Senior GP Dr Rankine, other VMC GPs, other VMC staff) was sought to finalise and establish the intervention at the VMC. This included, for example, discussing how stressed/distressed men present (e.g. with gastrointestinal symptoms, denial of mental health problems), and identifying which male patients GPs felt were currently poorly served by existing mental health services. As a result of these extensive discussions, the team co-designed an approach (including which men should be targeted by the Atlas Programme, pathways into the Programme, and appropriate terminology such as 'stress' and 'well-being' as opposed to 'mental health' language).

Atlas is delivered by experienced and senior practitioners, who have proven they can work in a 'male-sensitive' manner via a highly competitive interview selection process, and via working in the original successful Atlas study (Cheshire et al., 2016). Referrals are made to the Programme by VMC GPs, and inclusion criteria includes:

- Male
- Registered patient at the VMC (or Lees Place surgery, a branch of the VMC)
- Aged 18 years or over
- Suffering from stress or distressed, including somatic symptoms presentation

Exclusion criteria:

- Current substance abuse issues
- Serious mental health problems

Patients can have up to 12 sessions of counselling, acupuncture or a combination of the two. GPs decide in consultation with the patient which treatment(s) to refer patients to using a specially designed referral form for Atlas that was made available through the electronic patient notes system (EMIS, Egton Medical Information System). GPs recommend counselling to patients who would benefit from talking to a professional about their problems, and acupuncture to patients who could benefit from de-stressing, present with somatic symptoms and/or who may be willing to subsequently engage in talking therapy following acupuncture. In addition, Atlas practitioners can cross-refer their patient to the other Atlas modality, if they feel that would be helpful for the patient. All Atlas sessions are

held on VMC premises, and patients are able to book their Atlas appointments through the VMC reception (in the same way they would book routine appointments).

Counselling
Patients referred to counselling receive up to 12 weekly sessions (lasting one hour) of integrative/humanistic counselling[1] (Rowan, 1992). This approach means that counsellors use a variety of tools appropriate for that patient, but always in a patient-centred way. During the first session, an assessment is conducted with the patient and an agreement to undertake a therapeutic counselling relationship is agreed. Sessions are delivered by experienced counsellors who have experience in working with men (for example, experience and successes with male clients, being 'male positive', understanding the specific concerns and the needs of men). Counsellors are registered with professional bodies (The UK Council for Psychotherapy and/or The British Association for Counselling and Psychotherapy).

Acupuncture
Patients referred to acupuncture receive up to six weekly sessions (lasting 30 minutes) of individualised Traditional Chinese Medicine (TCM) acupuncture treatment. Acupuncture sessions are delivered by senior acupuncturists who have experience of working in the NHS and with men, and are registered with the British Acupuncture Council. During the first session a full case history is taken along with traditional pulse and tongue diagnosis. From these, a treatment plan is developed to reduce patients' psychological and/or somatic symptoms, which can be adjusted each week depending on the patient's response to treatment.

The Atlas men's wellbeing programme was initially piloted at the VMC in March 2013 until July 2014, and had 107 men attending sessions. Findings from the pilot evaluation showed that significant improvements pre- versus post- Atlas were obtained in the areas of anxiety, perceived stressed, positive well-being, physical health and patient-centred outcomes (i.e. problems identified as the most important to each man). A sub-sample (n=50) of men who were depressed before using the programme also experienced significant improvements in depression post-treatment. In all, 78% of patients said that they felt better after their Atlas sessions, 13% reported no change and 4% felt a little worse. High acceptability of the Atlas was reported among both men and VMC staff. Reductions in costs related to health and social care usage and lost employment exceeded the cost of the Atlas counselling/acupuncture sessions, with an average saving of nearly £700 per patient (Cheshire et al., 2016). Owing to the success of the pilot, funding was obtained to continue running Atlas (Atlas 2.0) at the VMC from September 2017 to present day (December 2020), although the programme was temporarily put on hold due to Covid-19. This report presents the evaluation of the Atlas 2.0 service that continued after the initial study.

[1] Humanist therapy includes a broad range of approaches that take a non-medical, non-pathologising approach, treating the individual as unique, with a potential to grow, focusing on a holistic approach, where the therapist-client relationship is important.

The Evaluation

Data collection

Bespoke questionnaires – designed in close consultation with our Expert Advisory Panel to include accepted scales – were used to collect predominantly quantitative data from patients' pre-treatment (before attending their Atlas sessions) and post-treatment (on completion of all their Atlas sessions). Additional open text (qualitative) questions were included on the questionnaires. The following data were collected:

Hospital Anxiety and Depression Scale (HADS)

Anxiety and depression were measured using the Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983). The HADS measures both anxiety and depression and is quick and easy to complete. The questionnaire comprises seven questions for anxiety and seven questions for depression. Each item is scored on a scale of 0 to 3, therefore scores range from 0 to 21, with higher scores indicating greater anxiety and greater depression. The HADS was designed to detect anxiety and depression in non-clinical populations. The HADS performs well in identifying and assessing the symptom severity of anxiety disorders and depression in the general population, and somatic and primary care patients; and provides recommended cut-offs for low, medium and high risk of anxiety and depression (Zigmond & Snaith, 1983).

Perceived stress Scale (PSS)

The extent of generally appraised life stress was measured by the 10-item version of the Perceived Stress Scale (PSS; Cohen, Kamarck & Mermelstein, 1983). The 10 PSS items explore feelings and thoughts during the last month. Respondents indicated the extent to which they experienced feelings such as "Felt that you were unable to control the important things in your life" and "Felt difficulties were piling up so high that you could not overcome them" using a 5-point Likert scale ranging from 0 (never) to 4 (very often). Scores are summed to give a total score of between 0 and 40, with higher scores indicating increased stress. The PSS has established validity and reliability (Cohen, Kamarck & Mermelstein, 1983).

Warwick-Edinburgh Mental Well-being Scale

Positive well-being was measured using the Warwick-Edinburgh Mental Well-being Scale (WEMWBS; Tennant et al., 2007). The WEMWBS is a measure of positive mental well-being encompassing items which assess both the hedonic (pleasure) and eudaimonic (virtue, using one's potential and skills) perspectives of happiness. We used the shorter seven-item version of the scale which not only is quicker to complete but may also be more robust than the 14-item version (Stewart-Brown, et al., 2009). Items have five response categories (none of the time, rarely, some of the time, often, all of the time). Responses are scored from 1 to 5 and transformed so they are comparable with the 14 item scale, total score scale scores range from 7 to 35. The scale has established validity and reliability (Tennant et al., 2007). The scaling properites of the seven items are superior to the 14 items, therefore, the raw scores were transformed into metric scores.

Patient Health Questionnaire-9 (PHQ-9)
The Patient Health Questionnaire-9 (PHQ-9; Kroenke, Spitzer, & Williams, 2001) is the 9-item depression module from the full PHQ (Spitzer, Kroenke & Williams, 1999). The PHQ-9 comprises nine items that pertain to DSM-IV criteria for major depressive disorder (MDD). The PHQ-9 rates the frequency of depressive symptoms in the preceding two weeks on a 0–3 Likert-type scale; summed scores range from 0 to 27. The PHQ-9 yields an index of depressive symptom severity with scores of 1–4 indicating no depression, 5–9 mild depression, 10–14 moderate depression, 15–19 moderately severe depression and 20–27 severe depression. The PHQ-9 has demonstrates good psychometric properties (sensitivity 0.80, specificity 0.92) (Gilbody et al., 2007).

In addition to the above questionnaires, a number of single item questions were included. Participants were asked if they were using anything to help deal with their stress (i.e. prescription medication, over the counter remedies, alcohol, other). Physical health was measured using an 11-point Likert scale anchored 0 (extremely poor) to 10 (Excellent).
On the pre-treatment questionnaire demographic data (age, ethnicity) were collected and patients were asked how they had first heard about Atlas.

Qualitative data were collected via open-ended questions (providing free text boxes for answers) at the end of questionnaires. The pre-treatment questionnaire asked patients to name the main benefit they hoped to gain from attending. The post-treatment questionnaire also asked patients about benefits; anything they had learnt from using Atlas; what they thought about practitioners and the service they provided; any improvements that could be made to the Programme; and if there was any other comments they would like to make about the Programme.

Participants
All patients referred to Atlas 2.0 were invited to take part in the evaluation. In total, 45 men were referred to the service by their GP, 25 men attended sessions and 16 completed all their evaluation materials.

Procedure
On referral to Atlas 2.0 by their GP, patients were asked to go to reception and pick up an evaluation pack and book their Atlas appointments. Evaluation packs comprised a covering letter, patient information sheet, consent form, pre-questionnaire and an envelope. Prior to their first session patients returned their completed pre-treatment questionnaire and consent form in the sealed envelope to the VMC reception, which was later collected by a researcher. Patients were given their post-treatment questionnaire by the VMC receptionist once they had finished using Atlas (i.e. completed all their counselling/ acupuncture appointments or withdrawn). Questionnaires did not use patient names, rather date of birth and initials for identification.

Ethical approval was obtained from the University of Westminster Research Ethics Committee (ref: ETH1819-1998).

Data analysis

Quantitative data were analysed using SPSS version 25. Statistical significance was set at the 5% level. To ensure a conservative analysis, non-parametric tests (Mann Whitney-U, Wilcoxon Signed Rank, Kruskal-Wallis, McNemar and Chi-square as appropriate) were used throughout. To examine patient outcomes Wilcoxon Signed Rank tests were used to compare pre- and post-treatment data including the HADS, PSS, WEMWBS, PHQ and physical health. Effect sizes were calculated by dividing the z value by the square route of N. Magnitude of effect sizes were established using the Cohen (Cohen, 1998) criteria of 0.1 = small effect, 0.3 = medium effect and 0.5 = large effect. Differences in patient outcomes by treatment received (ie acupuncture, counselling or both) were not examined due to insufficient numbers in the treatment groups.

Percentage of participants experiencing a clinically meaningful improvement for the HADS was determined using the recommended change of 1.5 points on each subscale (Puhan, 2008).

Qualitative data collected from open-ended questions on the questionnaires were analysed using thematic analysis (Braun &Clarke, 2006). The researcher immersed herself in the data, highlighting key sections of text and words. An initial list of themes/codes was developed and then organised into themes to create a final coding list.

Findings

The following section of the report presents participant demographics and information on patient outcomes, such as changes in anxiety, depression and wellbeing, and is based upon the 16 patients that completed both pre- and post-treatment questionnaires (n=16).

Participant characteristics (n=16)

There was a wide range of ages (34 to 73 years old) and a mix of ethnicities attending Atlas and participating in the evaluation. The majority of participants were in employment and 18.8% were retired. The proportion of the sample that were unemployed (6.3%) was similar to the London unemployment rate (4.6%) (ONS, 2019), see Table 1 and Figure 1. All participants had heard about Atlas through their GP.

A quarter of participants were taking prescribed medication to help deal with their stress/distress, however, nearly half of participants were using alcohol to help them cope (see Table 2).

Levels of anxiety and depression pre-treatment were examined, using HADS data. The findings indicate that patients referred to the services self-reported a wide range of levels of anxiety and depression, however anxiety was much more prevalent in this population than depression. This reflects the remit of the programme, which was tailored for patients suffering from everyday ‘stress or distress’ rather than diagnosable depression (see Table 3).

Table 1: Participant Demographics

Age (years)	Mean: 53 Range: 34-73
Employment	
Paid or self-employed	75.0%
Unemployed	6.3%
Retired	18.8%
Ethnicity	
White – British	81.3%
White – European/other	6.3%
Asian	6.3%
Mixed	6.3%

Figure 1: Histogram showing the age distribution of participants

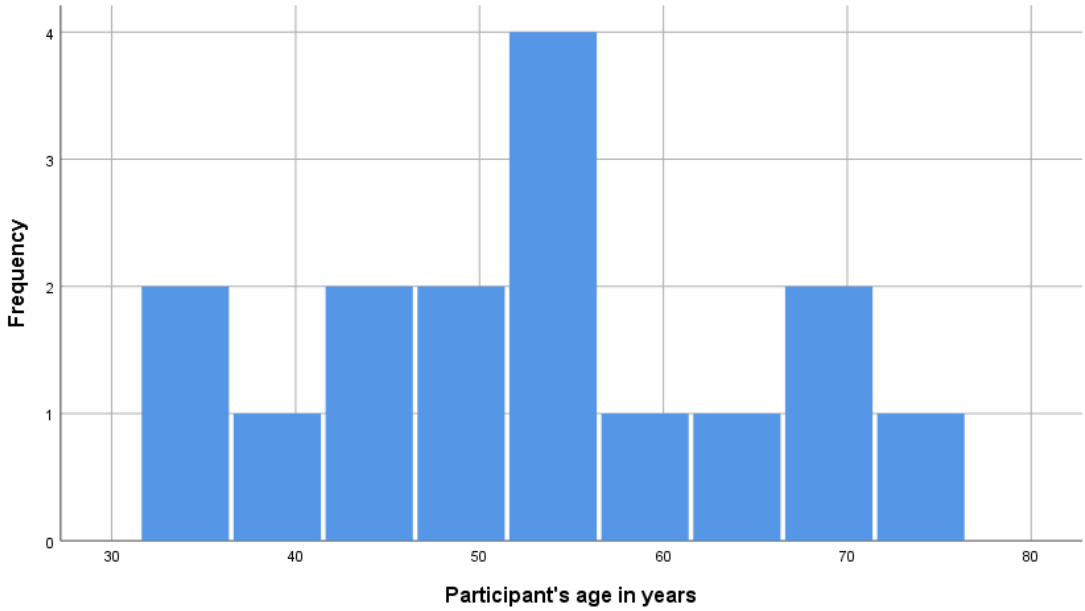


Table 2: Medication and drugs taken by patients to manage distress, in the two weeks prior to commencing their Atlas sessions

	Percentage of patients
Prescription medication	25.0
Over the counter medication/remedies	18.8
Alcohol	43.8
None	25.0

Patient outcomes

Participant baseline and post-treatment data were compared. Findings reported here provide an indication of changes for participants after taking part in Atlas, but should nevertheless be interpreted with caution due to the small sample size (n=16) and lack of control data.

Changes in anxiety and depression

Comparisons between pre- and post-treatment revealed a statistically significant improvement in anxiety (p = 0.006) with a large effect size (r=0.49). There was no change in depression (0.801), see Table 3.

Applying the change score of 1.5 points for minimally important change (Puhan, 2008), 11 (68.8%) patients experienced a clinically meaningful change in their anxiety and 7 (43.8%) patients experienced a clinically meaningful change in their depression.

Table 3 – Anxiety and depression scores (HADS) pre- and post-treatment

	Pre-treatment Median (interquartile range)		**Post-treatment Median (interquartile range)**		**p-value**	**Effect size**
HADS – anxiety (range 0-21 ↑ = worse)	14.0	(10.0-16.8)	10.5	(7.0-13.8)	0.006	0.49
HADS – depression (range 0-21 ↑ = worse)	10.0	(6.3-13.5)	8.0	(7.3-12.5)	0.801	NA

Changes in other variables

Comparisons between pre- and post-treatment revealed a statistically significant improvement in perceived stress (p=0.009) with a medium effect size (r=0.46). For other study variables, although numbers were moving in the right direction, there were no statistically significant changes in positive wellbeing (WEMWBS) (p= 0.125), physical health (p = 0.716) and the PHQ (p= 0.211), see Table 4.

Table 4 – Study variable scores over time pre- and post-treatment

	Pre-treatment Median (interquartile range)		Post-treatment Median (interquartile range)		p-value	Effect size
PSS (range 0-40 ↑ = worse)	27.0	(20.3-30.0)	22.0	(16.5 -25.8)	0.009	0.46
WEMWBS (range 7-35 ↑ = better)	18.0	(16.4-20.5)	19.6	(16.3-23.7)	0.125	NA
Physical health (range 0-10 ↑ = better)	6.0	(5.0-7.0)	7.0	(5.0-8.0)	0.716	NA
PHQ (range 0-27 ↑ = worse)	13.5	(10.3-17.0)	8.0	(5.3- 17.3)	0.211	NA

Qualitative findings

Qualitative data corroborated the quantitative findings, supporting the notion of improved participant mental health after attending Atlas sessions. Key benefits participants reported gaining from attending the programme highlighted by the qualitative data included stress and anxiety reduction, improvements to mental health, as well as an improved general sense of wellbeing.

> *"I feel much better physically and mentally."*
> *"I am more at peace with myself."*

Qualitative findings extended our understanding of improvements in mental health, indicating how these changes may have occurred. For example, a key benefit highlighted by participants was the greater awareness they had gained: participants reported an improved understanding of themselves and their issues, this included acknowledging the importance of taking care of one's mental health:

> "*This helped me a lot understanding my anxiety.*"
> "*That I am important, and my wellbeing is too, and that I have to make changes in my life."*
> *"Realisation that I had anger issues relating to my marriage breakdown but more importantly understanding the underlying reasons for that anger."*

Participants also discussed the lessons that they learned from taking part in Atlas, describing techniques they had learned to apply in order to manage their stress and anxiety. For example, the importance of their working with their emotions. One participant reported simply feeling more confident in managing his issues.

"*I have more courage. I can now deal with my situation. I feel stronger & more powerful. I am more at peace with myself.*"
"Learned techniques to deal with anxiety, to question my emotions rather than bottle them up."

A small number of participants highlighted some of the specific techniques that were beneficial to managing their emotions, as well as some activities that they planned on doing as a result of the programme (e.g. massage, acupuncture, positive thinking):

"…Coping techniques to avoid becoming angry, breathing exercises and visualisation."

"To take every moment as it comes. To breathe & ground myself."

One participant noted a significant improvement in his physical health as a result of changes he had made:

"*I was in a very bad place, with suicidal thoughts. I am now feeling emotions, taking a more active control of my life. My chronic headaches have virtually disappeared and my anxiety is under better control."*

All participants were particularly complimentary about their Atlas practitioner, who were often described as "excellent", as well as insightful, knowledgeable, friendly and professional. Some participants had received both acupuncture and counselling, noted that the combination had worked well together.

"I cannot praise them enough, they are so professional. They explained what was happening to me at every step, I was put at ease at all times. If I had any questions they were answered at a level I could understand."

"I am incredibly impressed with [counsellor] and [acupuncturist]. The combination of counselling & acupuncture work well together. I felt they both cared about me achieving a positive & sustained change."

Although most participants felt Atlas was very good and couldn't suggest any improvements. Many participants did feel that more sessions would be very helpful, pointing out that for most issues or to achieve long lasting change more than the 6 sessions offered by Atlas would be necessary.

"More sessions would most definitely help in 6 sessions you only really have time to start to relay the issues to the counsellor and begin to understand how the process works."

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